

Department of Human Services  
Bureau of Human Service Licensing  
LICENSING INSPECTION SUMMARY - PUBLIC

August 6, 2025

[REDACTED], MANAGING DIRECTOR  
HIDDEN MEADOWS OPCO LLC

RE: HIDDEN MEADOWS ON THE RIDGE  
340 FARMERS LANE  
SELLERSVILLE, PA, 18960  
LICENSE/COC#: 14523

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/12/2025, 05/12/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *HIDDEN MEADOWS ON THE RIDGE* License #: *14523* License Expiration: *07/20/2025*  
Address: *340 FARMERS LANE, SELLERSVILLE, PA 18960*  
County: *BUCKS* Region: *SOUTHEAST*

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: *HIDDEN MEADOWS OPCO LLC*  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *09/02/2010* Issued By: *West Rockhill Township*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *60* Waking Staff: *45*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal* Exit Conference Date: *05/13/2025*

**Inspection Dates and Department Representative**

05/12/2025 - On-Site: [REDACTED]  
05/12/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *60* Residents Served: *49*

**Secured Dementia Care Unit**

In Home: *No* Area: Capacity: Residents Served:

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *49*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *11* Have Physical Disability: *1*

**Inspections / Reviews**

**05/12/2025 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/16/2025*

**06/30/2025 - POC Submission**

Submitted By: [REDACTED] Date Submitted: *08/03/2025*  
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/03/2025*

Inspections / Reviews (*continued*)

## 07/11/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 08/03/2025

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 07/18/2025

## 07/28/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 08/03/2025

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 07/31/2025

## 08/06/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 08/03/2025

Reviewer: [REDACTED] Follow-Up Type: Not Required

65f - Training Topics

1. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff member A did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and personal care service needs of the resident during training year 2024.

Plan of Correction

Accept ( [REDACTED] - 07/11/2025)

Staff A will complete the missing training by 7/30/25 on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and personal care service needs of the resident.

Plan of Correction

Executive Director or designee will audit all employees who work in Hidden Meadows to make sure they complete all mandatory trainings. Audits will begin the week of June 16 and continue until all staffs' trainings have been reviewed.

Training will be provided to any employees lacking the required training.

Executive Director provided education regarding mandatory training requirements during staff meeting on June 26,2025.

Training compliance will be reviewed each quarter during QA meetings. Those employees who are not meeting targeted hours will be identified. Next QA meeting is scheduled for 7/24/25. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 07/30/2025

65f - Training Topics (continued)

Implemented (████) - 07/28/2025)

65g - Annual Training Content

2. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons A and B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and resident rights during training year 2024.

Repeat Violation - RI - 5/21/2024 et al.

Plan of Correction

Accept (████) - 07/11/2025)

Staff A and B will complete training by 7/30/25 on fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and Executive Director will review resident rights with both Staff A and B.

Executive Director or designee will audit all employees who work in Hidden Meadows to make sure they complete all mandatory trainings including fire safety. Training will be provided to any employees lacking the required training.

Executive Director provided education regarding mandatory training requirements during staff meeting on June 26,2025.

Training compliance will be reviewed each quarter during QA meetings. Those employees who are not meeting targeted hours will be identified. Next QA meeting is scheduled for 7/24/25. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 07/30/2025

Implemented (████) - 08/06/2025)

96a - First Aid Kit

3. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit located in the third-floor nurse's office does not include scissors.

96a - First Aid Kit (continued)

**Plan of Correction**

Accept (████) - 06/30/2025

*At the time of inspection, Health and Wellness Director added scissors to the first aid kit.*

*Executive Director reminded Health and Wellness Director the complete list of items that are required in each first aid kit.*

*Monthly audits on all first aid kits have started in June 2025 and will continue monthly.*

*Executive Director will review monthly audits at quarterly QA meetings. The next QA meeting is scheduled for July 24, 2025.*

**Licensee's Proposed Overall Completion Date: 07/24/2025**

Implemented (████) - 07/28/2025

103g - Storing Food

**4. Requirements**

2600.

103.g. Food shall be stored in closed or sealed containers.

**Description of Violation**

*On 05/13/2025 at 09:15 AM, a bag of baking powder and two bags of sugar, which were opened but were not tightly sealed, were found on the dry storage shelf of the home's main kitchen.*

**Plan of Correction**

Accept (████) - 06/30/2025

*Immediately during walk with inspector, Executive Director threw out the baking powder and bags of sugar..*

*Culinary staff along with direct staff at the home during inspection, were educated on the spot to make sure all food items are tightly sealed stored appropriately.*

*Director of Culinary along with Executive Director will discuss this violation at team meeting scheduled on 6-26-25 and made*

*all staff aware of the regulation that all food items must be labeled and tightly sealed.*

*Executive Director and or Culinary Director will be completing daily audits starting June 16, 2025.*

*Audits will continue for 2 months or until substantial compliance achieved.*

*Food Service food storage audits will be discussed at quarterly QA meetings. The next QA meeting will be held on July 24, 2025. Minutes of this meeting will be documented and filed.*

**Licensee's Proposed Overall Completion Date: 07/24/2025**

Implemented (████) - 07/28/2025

103i - Outdated Food

**5. Requirements**

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food (continued)

**Description of Violation**

*On 05/13/2025 at 09:20 a.m., a bag of stuffed shells and a half-used bag of chicken cordon bleu were found in the walk-in freezer of the home's main kitchen; not in their original containers and were unlabeled and undated.*

**Plan of Correction**

**Accept (█ - 06/30/2025)**

*Immediately during walk with inspector, Culinary Director threw up the unlabeled stuffed shells and chicken.*

*Culinary staff along with direct staff at the home during inspection, were educated on the spot to make sure all food items are placed in original containers and labeled and dated.*

*Director of Culinary along with Executive Director will discuss this violation at team meeting scheduled on 6-26-25 and made*

*all staff aware of the regulation that all food items must be placed in original containers and labeled and dated.*

*Executive Director and or Culinary Director will be completing daily audits starting June 16, 2025.*

*Audits will continue for 2 months or until substantial compliance achieved.*

*Food Service food storage audits will be discussed at quarterly QA meetings. The next QA meeting will be held on July 24, 2025. Minutes of this meeting will be documented and filed.*

**Licensee's Proposed Overall Completion Date: 07/24/2025**

**Implemented (█ - 07/28/2025)**

107d - Procedure Emergency Management Agency Submission

**6. Requirements**

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

**Description of Violation**

*The home's written emergency procedures have not been reviewed, updated, and submitted since March 14, 2024, to the local emergency management agency.*

**Plan of Correction**

**Accept (█ - 06/30/2025)**

*Executive Director has reached out to Rockhill Township Emergency Management official to make sure they are the correct person to send update Emergency Management plan for Hidden Meadows.*

*Executive Director has emailed the Emergency Management █ our updated Emergency Procedures. Executive Director has asked for email response that plan was received, along with a written statement. Response was sent back and on 6-28-25 revised emergency plan was sent via email.*

*Required annual compliance documents such as Emergency Management and local fire chief notification will be reviewed each quarter during QA meetings. Next QA meeting is scheduled for 7/27/25. A summary from each QA meeting will be drafted and filed.*

107d - Procedure Emergency Management Agency Submission (continued)

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ( ) - 07/28/2025

183e - Storing Medications

7. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/13/2025, a 1 1/4 loose pill was on the first drawer of the medication cart on the 2nd floor.

Plan of Correction

Accept ( ) - 06/30/2025

Loose pill was properly destroyed by Health and Wellness Director immediately after being found.

Staff members responsible for medication administration will make sure all medication is accounted for daily. Education has been provided for med techs and nurses 6-4 through 6-6 by Health and Wellness Director. Executive Director reviewed and educated staff at staff meeting held on 6-26-25.

Health and Wellness Director will conduct Med cart audits starting on 6-16-25 and will continue until 7-27-25 or until substantial compliance has been met.

Pharmacy will provide their own med cart audits on a monthly basis and report any findings to Health and Wellness Director.

All medication cart audits will be reviewed and discussed at quarterly QA meetings. The next QA meeting will be held on

July 24, 2025. Minutes of this meeting will be documented and filed.

Licensee's Proposed Overall Completion Date: 07/24/2025

Implemented ( ) - 07/28/2025

8. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/13/2025, resident 1's Hydrocodone-Acetaminophen medication card has an opening on the back of pill #8.

Plan of Correction

Accept ( ) - 06/30/2025

Health and Wellness Director reviewed all remaining medications in Med cart to make sure packaging integrity was intact. No other medication cards had any noticeable openings.

Staff members responsible for medication administration will make sure all medications and stored appropriately and there's no damage to the packaging. Any openings found will be immediately removed and reported to Health

183e - Storing Medications (continued)

and Wellness Director. Education has been provided at staff meeting held on 6-26-25.

Health and Wellness Director will conduct Med cart audits starting on 5-1-25 and will continue until 7-27-25 or until substantial compliance has been met.

Pharmacy will provide their own med cart audits on a monthly basis and report any findings to Health and Wellness Director.

All medication cart audits will be reviewed and discussed at quarterly QA meetings. The next QA meeting will be held on

July 24, 2025. Minutes of this meeting will be documented and filed.

Licensee's Proposed Overall Completion Date: 07/24/2025

Implemented (████) - 07/28/2025

9. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Lorazepam 2 mg expired on 1/15/2025 for resident 2 was observed in the medication station locked refrigerator.

Lorazepam 2 mg expired on 3/27/2025 for resident 3 was observed in the medication station locked refrigerator.

Plan of Correction

Accept (████) - 07/11/2025

Loose pill was properly destroyed by Health and Wellness Director immediately after inspection on June 13, 2025 by Lpn ██████ using drug buster.

All nursing and medication techs will be educated by Health and Wellness Director or Designee by July 30th on how to identify expired medications and how to properly discard the medication.

Health and Wellness Director will conduct Med cart audits starting on 5-1-25 and will continue until 7-27-25 or until substantial compliance has been met.

Pharmacy conducted their own med cart audits on Sunday June29th. Written findings were given to Health and Wellness Director.

All medication cart audits will be reviewed and discussed at quarterly QA meetings. The next QA meeting will be held on

**183e - Storing Medications (continued)**

July 24, 2025. Minutes of this meeting will be documented and filed.

Licensee's Proposed Overall Completion Date: 07/30/2025

Implemented (████) - 07/28/2025

**187a - Medication Record****10. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

**Description of Violation**

Resident 4 is prescribed Insulin Lispro 100 units/ML pen; inject SQ before meals per sliding scale: BS 150-200: 6 units, 201-250: 8 units, 251-300: 10 units, 301-350: 12 units, 351-400: 14 units. The medication administration record did not indicate the number of units of insulin administered to resident 4 from May 1st through May 12th as prescribed.

**Plan of Correction**

Accept (████) - 07/11/2025

On 5/14/2025 ECP team leader ██████████ replied to our Health and Wellness Director via email showing the necessary steps to make sure units and doses of insulin are documented. Attached is the email showing details on how to properly document insulin. Our Health and Wellness Director individually showed all nursing and medication techs on the new procedures. Documentation is provided showing the correct insulin information.

Additional training will be given by Health and Wellness Director or Designee by July 30th to ensure all staff are aware of proper procedure to document insulin in Emar.

As an ongoing measure, Health and Wellness Director will also conduct weekly audits beginning 5-27-25 to ensure glucometer readings and units of insulin are being appropriately entered into the Emar record.

Audits will continue for two months or until substantial compliance to make sure glucometers readings are accurate, and documentation is consistent.

Executive Director will review audits for glucometers at quarterly QA meetings. The next QA meeting is scheduled for July 24, 2025.

Licensee's Proposed Overall Completion Date: 07/30/2025

187a - Medication Record (continued)

Implemented ( [REDACTED] - 07/28/2025)

187d - Follow Prescriber's Orders

11. Requirements

2600.  
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 4 is prescribed Insulin Lispro 100 units/ML pen; inject SQ before meals per sliding scale: BS 150-200: 6 units, 201-250: 8 units, 251-300: 10 units, 301-350: 12 units, 351-400: 14 units. The medication administration record did not indicate the number of units of insulin administered to resident 4 from May 1st through May 12th as prescribed by the resident's physician.

Plan of Correction

Accept ( [REDACTED] - 07/11/2025)

On 5/14/2025 ECP team leader [REDACTED] replied to our Health and Wellness Director via email showing the necessary steps to make sure units and doses of insulin are documented. Attached is the email showing details on how to properly document insulin. Our Health and Wellness Director individually showed all nursing and medication techs on the new procedures. Documentation is provided showing the correct insulin information.

Additional training will be given by Health and Wellness Director or Designee by July 30th to ensure all staff are aware of proper procedure to document insulin in Emar.

As an ongoing measure, Health and Wellness Director will also conduct weekly audits beginning 6-16-25 to ensure glucometer readings and units of insulin are being appropriately entered into the Emar record.

Audits will continue for two months or until substantial compliance to make sure glucometers readings are accurate, and documentation is consistent.

Executive Director will review audits for glucometers at quarterly QA meetings. The next QA meeting is scheduled for July 24, 2025.

Licensee's Proposed Overall Completion Date: 07/30/2025

Implemented ( [REDACTED] - 07/28/2025)

190a - Completion Medication Course

12. Requirements

2600.  
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C, who has not successfully completed the Department-approved medications administration course in

190a - Completion Medication Course (continued)

2024, administered medications to residents, including resident 4's insulin Lispro, on 5/01/2025 at 7:26 a.m. and on 5/02/2025 at 16:26 p.m. and 19:25 p.m.

Plan of Correction

Accept (████ - 07/11/2025)

Staff member C has been trained in medication administration since ██████. It appears that several pages of ██████ training was mixed with another team members medication documents. I have enclosed all of staff members training since ██████. Plus, ██████ successfully past the train the trainer course this year.

Staff member has completed competency test on 5-13-25. see attached

Health and Wellness Director will review all remaining MedTech's to make sure their documentation is correct and filed appropriately.

Any new MedTech's initial test, course completion and competencies are reviewed by train the trainer.

Executive Director will review Medication Binder for Hidden Meadows prior to monthly QA meeting to ensure all Med Techs paperwork is complete and up to date. Next QA meeting is scheduled for 7/27/25. A summary from each QA meeting will be drafted and filed.

Licensee's Proposed Overall Completion Date: 07/03/2025

Implemented (████ - 07/28/2025)

227d - Support Plan Medical/Dental

13. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #5 uses a bedside mobility device to assist with transfer. However, the resident's assessment and support plan (RASP) dated ██████ does not address this use.

Repeat Violation - RI - 5/21/2024 et al.

Plan of Correction

Accept (████ - 06/30/2025)

Resident #5s assessment and support plan has been updated to include bedside mobility device.

Health and Wellness Director checked the remaining residents that use a bedside mobility device and made sure it was documented in the assessment and support plan.

Health and Wellness Director will review all current and new residents monthly to see if additional bedside mobility devices have been added and make sure they are included in the assessment and support plans.

227d - Support Plan Medical/Dental (continued)

Executive Director will review at quarterly QA meetings all the residents that use bedside mobility devices and this is stated on the assessment and support plan. The next QA meeting is scheduled for July 24, 2025.

Licensee's Proposed Overall Completion Date: 07/24/2025

Implemented (████) - 08/06/2025)

14. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The medication evaluation for resident 6, dated █████, indicates the resident has a need for a heart-healthy diet. The resident's assessment form and support plan, dated █████, does not document how this need will be met.

Plan of Correction

Accept (████) - 06/30/2025)

Resident #6s assessment and support plan has been updated to reflect how staff will encourage resident to follow heart healthy diet by giving them options by 7/24/25.

Health and Wellness Director checked the remaining resident's dietary needs by downloading the full diets and making sure they are correctly documented in the assessment and support plan.

Executive Director will have Culinary Department and or Health and Wellness bring a list of all residents diets to quarterly QA.

The next QA meeting is scheduled for July 24, 2025.

Proposed Overall Completion Date: 07/24/2025

Licensee's Proposed Overall Completion Date: 07/24/2025

Implemented (████) - 08/06/2025)